ARTICLE 17

SECTION 1

MEDI-CAL SPECIAL TREATMENT BENEFITS

(a) GENERAL

Limited Medi-Cal coverage is available to persons who need special types of life-sustaining medical treatment. These individuals must pay a percentage of their treatment costs, based on their net worth, which is a combination of property and income.

This special coverage is limited to persons in need of kidney dialysis or parenteral hyperalimentation treatment, also known as total parenteral nutrition or TPN. TPN provides total nutrient replacement for persons who are unable to eat and digest food.

There are two categories of Special Treatment benefits: Special Treatment Only and Special Treatment Supplement.

a. Special Treatment Only Benefits

i. Persons who need dialysis or TPN treatment, and are not eligible for regular Medi-Cal solely because of excess property, may be eligible for Medi-Cal Special Treatment Only benefits.

ii. The Special Treatment Only category uses the following two aid codes.

1. Aid Code 71 - Dialysis Only.
2. Aid Code 73 - TPN Only.

iii. Special Treatment Only beneficiaries receive a limited services Medi-Cal card.

b. Special Treatment Supplement Benefits

i. Employed persons who need dialysis or TPN treatment and who are eligible for regular Medi-Cal with a share of cost are also eligible for Medi-Cal Special Treatment Supplement benefits.

ii. The Special Treatment Supplement category uses the following aid codes.

1. Aid Code 71 - Dialysis Supplement.
2. Aid Code 73 - TPN Supplement.

MEM Proc. 17B-2

c. Beneficiary Portion of Special Treatment Benefit Costs

Special Treatment Benefit beneficiaries must pay a percentage of the cost of each dialysis or TPN service. The percentage is based on their annual net worth - a combination of property and annual gross income. Amounts paid toward this "Percentage Obligation" by Special Treatment Supplement beneficiaries can also be used to meet the regular Medi-Cal share of cost.

d. Other Health Coverage and the Billing Process

If the patient has Medicare, private health insurance, or any other non Medi-Cal coverage, that coverage must be billed first for the cost of a dialysis or TPN service. The patient's percentage obligation applies to the balance remaining after payment by the other coverage. For example, if Medicare covers $80 of a $100 charge, the patient's percentage obligation will be applied to the remaining $20. The provider subtracts the beneficiary's obligation from the $20 and bills Medi-Cal for the rest.

(b) APPLICATION PROCESS

Application for Special Treatment benefits are processed by specialized Eligibility Technicians located in the Kearny Mesa District Office. Applications are received and processed according to the procedures addressed in MPG Article 4 with the following additions and exceptions.

a. Additions

i. Form MC 210 is used as the statement of facts.

ii. The name of the Special Treatment benefit must be written in box 8 of the SAWS1.

iii. All Medi-Cal Special Treatment Supplement applicants must sign and date a Medi-Cal Special Treatment Supplement benefits client information statement at initial application and at redetermination interviews. The worker must also sign and date the statement and file the original under the "affirmation/declaration" tab in the case folder with form MC 210. The copy is given to the applicant. The form numbers are:

1. 14-30 DSS - Dialysis Medi-Cal Special Treatment Supplement benefits. (Appendix 17-1-A)

2. 14-31 DSS - TPN Medi-Cal Special Treatment Supplement benefits. (Appendix 17-1-B)

b. Exception

There is no retroactive eligibility to Medi-Cal Special Treatment benefits.

(c) ELIGIBILITY REQUIREMENTS

MEM PROC 17A

Medi-Cal Special Treatment Only Benefits

To be eligible for these benefits, a person must be all of the following in a month:

i. In need of dialysis or TPN and related services; and

ii. Not eligible for regular Medi-Cal solely because of excess property EXCEPT that applicants and beneficiaries for TPN only do not have to meet linkage requirements. They do not have to be aged, blind, disabled, under 21, the parent of a child deprived of parental support, or pregnant; and

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iii. Not currently eligible for renal dialysis Medicare if under age 65; and

iv. Meet standard citizenship, alien status, cooperation, residence, institutional status, and transfer of property requirements for Medi-Cal according to MPG Articles 4, 6, 7 and 9. TPN services are not considered restricted services.

1. For IRCA aliens, only those who are otherwise eligible and ABD or under 18 are entitled to State-only TPN services.

2. OBRA aliens are not eligible for State-only TPN services.

3. All TPN applicants are required to complete form MC-13, Section B "Scope of Benefits Requested" should have the "other" box checked and TPN services written in.

NOTE: If a Medi-Cal Special Treatment Only beneficiary loses eligibility because he/she becomes eligible for regular Medi-Cal, eligibility for Medi-Cal Special Treatment Supplement benefits must also be evaluated.

Medi-Cal Special Treatment Supplement Benefits

To be eligible for these benefits, a person must be all of the following in a month:

v. Eligible for Medi-Cal; and

vi. In need of dialysis or TPN and related services; and

vii. Employed or self-employed; and

viii. Earning, individually, a gross income that exceeds the Medi-Cal minimum maintenance need for one person.

Medicare eligibility does not affect eligibility for Special Treatment Supplement benefits.

NOTE: If a Medi-Cal Special Treatment Supplement beneficiary loses Supplement eligibility solely because of excess property, eligibility for Medi-Cal Special Treatment Only benefits must be determined.

Medicare Application

All applicants for Dialysis Special Treatment benefits must apply for Medicare Hospital coverage within ten days of applying for Special Treatment benefits. They must also supply the worker with a copy of the Medicare status within ten days of its receipt. Applicants who fail to apply for Medicare without good cause (criteria are listed in MPG Article 4) will have their application for Dialysis Special Treatment benefits denied.

Applicants for TPN Special Treatment benefits must follow the requirements of MPG Article 15, Section 4 in applying for regular Medicare, since there is no special Medicare assistance for this group.

(d) VERIFICATIONS

All Special Treatment benefit applicants or beneficiaries must provide the verifications required in MPG Article 4.

Additionally, all Dialysis Special Treatment benefit applicants or beneficiaries must provide verification of Medicare status as a condition of eligibility. Application/verification requirements are specified in MPG Article 15, Section 4 and MPG Article 4, Section 7. Receipt of Medicare affects Dialysis beneficiaries in the following ways:

Dialysis Only beneficiaries under age 65 lose Dialysis Only eligibility once Medicare eligibility is established.

Dialysis Supplement beneficiaries retain Dialysis Supplement eligibility but Medicare assumes most of the costs.

(e) BEGINNING DATE OF ELIGIBILITY

The beginning date of eligibility is the first day of the month of application, or the first of the month during which eligibility exists, whichever is later.

Examples:

a. The date of application is March 13. Eligibility is determined to exist starting in March. The beginning date of eligibility is March 1.

The date of application is March 13. Eligibility is determined to exist starting in April. The beginning date of aid is April 1.

(f) DETERMINATION OF ANNUAL NET WORTH

Calculation

To calculate the percentage of cost the beneficiary pays, the annual net worth must be determined first, using form MC 176D. This is done by combining:

i. The net market value of all available property; and

ii. The gross income reasonably expected to be received in a 12-month period by the person(s) whose property and income are considered. The 12-month period begins on the first of the month of initial eligibility.

Included Property and Income

The available property and income of the following persons will be considered when determining annual net worth:

iii. The beneficiary; and

iv. The beneficiary's spouse; and

v. The beneficiary's parents, if the beneficiary is all of the following:

1. Under 21 years of age; and

2. Unmarried; and

3. Living with his/her parents.

Excluded Property

The following real and personal property is excluded in determining annual net worth:

vi. One motor vehicle used for the transportation needs of the beneficiary or any member of the family; and

vii. The first $40,000 of market value of the beneficiary's is home. The remaining market value, less encumbrances, is included in the net worth determination. Allowable encumbrances are covered in MPG Article 9, Section 4; and

viii. The first $1,000 paid for life insurance placed in burial trusts for funeral, cremation or interment expenses; and

ix. Wedding and engagement rings, heirlooms, clothing, household furnishings and equipment; and

x. Equipment, inventory, licenses and materials owned by the applicant or beneficiary which are necessary for employment, for self-support or for an approved plan of rehabilitation or self-care necessary for employment is exempt as follows:

1. Motor vehicles necessary for employment or self-support, in addition to the motor vehicle exempt in 1); and

2. Other property necessary for employment or self-support in accordance with MPG Article 9, Section 8.

(g) DETERMINATION AND APPLICATION OF PERCENTAGE OBLIGATION

The percentage obligation is based on the annual net worth of the beneficiary as determined in item 6 above. The percentage obligation is applied to the cost of allowable services that remain unpaid after all other benefits or entitlements have been utilized. Form MC 176D is used for this calculation. (Appendix 17-1-C.)

Limitations

The amount of the percentage obligation cannot be:

i. Claimed against any Medi-Cal Special Treatment benefit; or

ii. Reimbursed by a third party.

Computation

The percentage obligations are used as follows:

iii. Medi-Cal Special Treatment Only beneficiaries:

1. Who have an annual net worth of less than $5,000 will be assigned a zero percentage obligation; or

2. Who have an annual net worth of $5,000 or more will be assigned a percentage obligation of two percent for each $5,000 of net worth, including the first $5,000. Round down to the nearest increment of $5,000.

iv. Medi-Cal Special Treatment Supplement beneficiaries:

1. Who have an annual net worth of less than $5,000 will be assigned a zero percentage obligation; or

2. Who have an annual net worth of $5,000 or more will be assigned a percentage obligation of one percent for each $5,000 of net

worth, including the first $5,000. Round down to the nearest increment of $5,000.

Examples:

v. Special Treatment Only beneficiary:

1. The amount of annual net worth is determined to be $4,500. The percentage obligation is 0.

2. The amount of annual net worth is determined to be $42,500. Divide 42,500 by 5,000 = 8. 8 x 2% is 16%. The percentage obligation is 16%. (Round down to the nearest increment of 5,000.)

vi. Special Treatment Supplement beneficiary:

1. The amount of annual net worth is determined to be $4,500. The percentage obligation is 0.

2. The amount of annual net worth is determined to be $42,500. Divide 42,500 by 5,000 = 8. 8 x 1% = 8%. The percentage obligation is 8%. (Round down to the nearest increment of 5,000.)

Required Budget Form

Form MC 176D is used to compute the amount of annual net worth and the percentage obligation. The form is filed on top of the right-hand side of the financial folder. Form MC 176D is required at application, re-application, restoration, change in net worth affecting percentage obligation, and at redetermination. Appendix 17-1-C is a sample of form MC 176D. Appendix 17-1-D gives instructions on completion of the form.

(h) SPECIAL TREATMENT SUPPLEMENT BENEFICIARY SHARE OF COST

Medical services other than those covered under Special Treatment benefits are subject to a share of cost as found in MPG Article 12, Section 1, instead of a percentage obligation. Costs paid by the beneficiary under Special Treatment Supplement benefits in any month are applied to the share of cost for that month. A beneficiary of an MFBU which has met its share of cost will be issued a regular Medi-Cal card according to the instructions in MPG Article 12, Section 2. The regular Medi-Cal card will be received in about six weeks.

All Medi-Cal services received by the beneficiary during that month will be covered under the provisions of the full Medi-Cal program rather than Special Treatment Supplement benefits once full coverage has been certified.

(i) CARD ISSUANCE

Initial Issuance

A MEDS on-line transaction must be completed to establish the Medi-Cal Special Treatment case on the MEDS record. The worker will complete a form 14-28 DSS and forward the form to the MEDS operator. The worker must be sure to include the beneficiary's percentage obligation on the form.

Change in Case Circumstances

Special Treatment cases require a MEDS on-line transaction whenever there is a change in case circumstances. Changes of address, percentage obligation, OHC and worker number all require an on-line transaction. The worker will complete a form 14-28 DSS to request the MEDS record change and forward the form to the MEDS operator.

(j) REPORTING RESPONSIBILITIES

Reporting Changes

i. Client Responsibility

The beneficiary is responsible for reporting changes as detailed in MPG Article 4, Section 2.

ii. Worker Responsibility

The worker must evaluate information received from any source to determine if benefit eligibility and/or the percentage obligation is affected and take appropriate action on reported changes.

DIALYSIS MEDI-CAL SPECIAL TREATMENT
SUPPLEMENT CLIENT INFORMATION
SAN DIEGO COUNTY – DEPT. OF SOCIAL SERVICES

If you need kidney dialysis and qualify for the Medi-Cal Dialysis Supplement Special Treatment Program, that program could reduce your out-of-pocket dialysis costs. Here are key facts and rules about the program.

I. Dialysis Supplement Eligibility Requirements

You must be all of these things in a month:

- In need of dialysis.
- Eligible for regular Medi-Cal with a personal or family share of cost.
- Employed, or self employed, with gross earnings which are greater than the individual Medi-Cal maintenance need for one person.
- Receiving either home dialysis or self-care clinic dialysis.

II. Information for Dialysis Supplement Eligibles

A. Advantages of Dialysis Supplement Program

This program provides you medical cost relief for dialysis and related services. Under the regular Medi-Cal program, you must pay all your surplus income toward meeting your share of cost for medical care. Under this program, you need pay only a percentage of the cost for dialysis services after any other health coverage payment is subtracted from the cost of those services.

B. Using Your Other Health Coverage

If you have Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be billed first for the cost of a dialysis service. Your percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers $80 of a $100 charge, your percentage obligation will be applied only to the remaining $20. The provider subtracts what you owe from the $20, and bills Medi-Cal for the rest.

C. What You Pay Toward the Cost of Your Dialysis Care

The amount you pay toward each dialysis service depends on the annual net worth of you and your spouse, or you and your parents if you are under 18. Annual net worth is annual income plus property holdings. The following are not counted as part of your property holdings:

The first $40,000 of your home's taxable value, one vehicle, $1,000 for burial expenses, burial plots or vaults, wedding and engagement rings, heirlooms, clothing, household furnishings, and household equipment.

If your annual net worth is less than $5,000, you pay nothing. If it is more than $5,000, you pay one percent of the net cost of each dialysis service for each $5,000 of annual net worth you have. For example, if your annual net worth is $15,000, you pay three percent of the net cost of each dialysis service. The percent you pay is called your "percentage obligation."

D. How Your Dialysis Supplement Eligibility Fits into Your Regular Medi-Cal Eligibility

Dialysis Supplement covers dialysis and related services only. If you or your family need other types of medical care, you must meet your regular Medi-Cal share of cost before you can receive a regular Medi-Cal card. The amount you pay for dialysis and related services as part of your Dialysis Supplement eligibility will be a credit against your share of cost, just the same as any other medical bill you pay. Be sure and have your dialysis provider or supplier fill out your "Record of Health Care Costs," form (MC 177). Once you receive a regular Medi-Cal card for any month, you must use it for all medical services, including dialysis, for the remainder of that month.

E. What Happens if You Lose Regular Medi-Cal Eligibility

Eligibility for Dialysis Supplement depends on eligibility for the regular Medi-Cal program. If you lose eligibility for regular Medi-Cal for any reason, including accumulation of excess resources, you will no longer be eligible for Dialysis Supplement. In this case, the county welfare department will determine your eligibility under the Dialysis Only program.

III. Services Covered by the Medi-Cal Dialysis Supplement Program

B. Dialysis Supplement Benefits

The Medi-Cal Dialysis Supplement program covers the full range of dialysis services except routine full-care dialysis. Routine full-care dialysis is not a Dialysis Supplement benefit. This exclusion does not preclude provision of full-care dialysis treatment in cases of a physician certified medical emergency. Dialysis Supplement coverage ends when you meet your regular Medi-Cal share of cost, since for the rest of the month you are entitled to free Medi-Cal services, including routine full-care dialysis.

C. Definition of Dialysis and Related Services

Dialysis and related services are defined in Title 22, California Administrative Code, Section 51157: "Renal Dialysis, Renal Homotransplantation, and Related Services" as follows:

(a) 'Renal dialysis' means removal by artificial means of waste products normally excreted by the kidneys. Such removal may be accomplished by the use of an artificial kidney or peritoneal dialysis on a continuing basis.*

(b) 'Renal homotransplantation' means the implantation of a kidney from one person to another for the treatment of renal disease.

(c) 'Related services' means hospital inpatient and physician's services related to the treatment of renal failure, stabilization of renal failure, treatment of complications of dialysis, and dialysis related laboratory tests, medical supplies, and drugs."

*(Note: "Renal dialysis" means full-care, self-care, or home-care dialysis.)

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D. Definitions of Types of Dialysis

1. Full-care dialysis is provided in a dialysis clinic or a hospital outpatient clinic. Treatment is fully managed by staff; the patient takes no part in managing his or her own care.

2. Self-care dialysis takes place in a "self-care dialysis unit" of a dialysis clinic or hospital outpatient clinic. The patient manages his or her own treatment with less staff supervision required.

3. Home dialysis takes place in the home. The patient has a home dialysis unit and dialyzes at home. Usually a dialysis clinic or outpatient hospital clinic will supervise the patient's home care and will provide needed supportive services, including the services of qualified home dialysis aides on a selective basis.

IV. Your Responsibilities

A. Medicare Application

1. You must apply for Medicare coverage within ten days of making application for this program unless you already have Medicare coverage or have a statement from Social Security showing you are currently not eligible for Medicare.

2. You must provide the county welfare department a copy of the Social Security Medicare status, or any evidence of eligibility such as a card or letter, within ten days of receipt.

3. If you are not currently eligible for Medicare, you must request a statement of quarters of coverage from Social Security (Social Security Benefit Estimate Form). You should determine, with the aid of a Social Security representative, how many more quarters of coverage you need to become eligible for Medicare. This information must be given to the county welfare department or your eligibility will have to be redetermined every quarter. It is to your direct advantage to apply for Medicare as soon as you believe you are eligible. The cost you must pay is based on the balance left after Medicare or any other insurance has paid. Medicare coverage can reduce your cost up to 80 percent.

B. General Reporting Responsibilities

You must report any change in status that could affect your dialysis program eligibility or your percentage obligation. These include, but are not limited to:

- Loss of employment.
- Change in marital status.
- Increase/decrease in earnings.
- Change in other health coverage.

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I have reviewed the above information with the county representative. I understand my responsibilities in regard to Medicare and general reporting requirements.

Applicant	Date

I have explained the Medi-Cal Dialysis Supplement requirements listed above to the applicant.

County Representative	Date

14-30 DSS

TPN MEDI-CAL SPECIAL TREATMENT
SUPPLEMENT CLIENT INFORMATION
SAN DIEGO COUNTY – DEPT. OF SOCIAL SERVICES

If you require parenteral hyperalimentation treatment, also known as total parenteral nutrition (TPN), and qualify for the Medi-Cal TPN Supplement program, that program could reduce your out-of-pocket TPN costs. Here are key facts and rules about the program.

I. TPN Supplement Eligibility Requirements

You must be all of these things in a month:

- In need of TPN.
- Performing home TPN treatment.
- Eligible for regular Medi-Cal with a personal or family share of cost.
- Employed, or self-employed, with gross monthly earnings, which are greater than the individual Medi-Cal maintenance need for one person.

II. Information for TPN Supplement Eligibles

A. Advantages of TPN Supplement Program

This program provides you medical cost relief for home TPN treatment. Under the regular Medi-Cal program, you must pay all your surplus income toward meeting your share of cost for medical care. Under this program, you need pay only a percentage of the cost for home TPN treatment after any other health coverage payment is subtracted from the cost of those services.

B. Using Your Other Health Coverage

If you have Medicare, private health insurance, or any other non-Medi-Cal coverage, that coverage must be utilized or billed first for the cost of home TPN treatment. Your percentage obligation applies to the balance remaining after payment by such other coverage. For example, if Medicare covers $80 of a $100 charge, your percentage obligation will be applied only to the remaining $20. The provider subtracts what you owe from the $20 and bills Medi-Cal for the rest.

C. What You Pay Toward the Cost of Your Home TPN Treatment

The amount you pay toward your home TPN treatment depends on the annual net worth of you and your spouse, or you and your parents if you are under 18. Annual net worth is annual income plus property holdings. The following are not counted as part of your property holdings:

The first $40,000 of your home's taxable value, one vehicle, $1,000 for burial expenses, burial plots or vaults, wedding and engagement rings, heirlooms, clothing, household furnishings, and household equipment.

If your annual net worth is less than $5,000, you pay nothing. If it is $5,000 or more, you pay one percent of the net cost of your home TPN treatment costs for each $5,000 of annual net worth you have. For example, if your annual net worth is $15,000, you pay three percent of the net costs of your home TPN treatment costs. The percent you pay is called your "percentage obligation."

D. How Your TPN Supplement Eligibility Fits Into Your Regular Medi-Cal Eligibility

TPN Supplement covers home TPN supplies and related services only. If you or your family need other types of medical care, you must meet your regular Medi-Cal share of cost before you can receive a regular Medi-Cal card. The amount you pay for home TPN supplies and related services as part of your TPN Supplement eligibility will also be a credit against your share of cost, just the same as any other medical bill you pay. Be sure and have your medical provider or supplier fill out your "Record of Health Care Costs," form MC 177. Once you receive a regular Medi-Cal card for any month, you must use it for all medical services, including TPN, for the remainder of that month.

E. What Happens if You Lose Regular Medi-Cal Eligibility

Eligibility for TPN Supplement depends on eligibility for the regular Medi-Cal program. If you lose eligibility for regular Medi-Cal for any reason, including accumulation of excess resources, you will no longer be eligible for TPN Supplement. In this case, the county welfare department will determine whether you are eligible under the TPN Only program.

III. Services Covered by the Medi-Cal TPN Supplement Special Treatment Program

A. TPN Supplement Benefits

The TPN Supplement Special Treatment Program covers only a limited range of outpatient benefits. You may use your TPN Supplement Medi-Cal card for approved nutrient solutions and related supplies, related laboratory services, and outpatient physician visits.

If you require treatment for an underlying condition, acute hospital care, or other forms of medical care, you must meet your regular Medi-Cal share of cost before Medi-Cal will pay for these services.

IV. Your Responsibilities

A. Medicare Application

You must apply for Medicare coverage after you apply for this program if you are receiving Social Security Title II Disability benefits.

You must provide the county welfare department with a copy of the Social Security Medicare status statement, or any evidence of eligibility such as a card or letter, within 60 days of your Medicare application. If Social Security does not provide you with a Medicare status statement within 60 days, you must provide a copy to the county welfare department as soon as you do receive it.

B. General Reporting Responsibilities

You must report any change in status that could affect your TPN Supplement Special Treatment Program eligibility or your percentage obligation. Such changes include, but are not limited to:

- Loss of employment.
- Change in marital status.
- Increase/decrease in earnings.
- Change in other health coverage.

I have reviewed the above information with the county representative. I understand my responsibilities in regard to Medicare and general reporting requirements.

Applicant	Date

I have explained the Medi-Cal TPN Supplement requirements listed above to the applicant.

County Representative	Date

14-31 DSS

SPECIAL TREATMENT WORKSHEET

State of California – Health and Human Services Agency

Department of Health Services
Medi-Cal Program

County District	County Use

MEDI-CAL SPECIAL TREATMENT PROGRAMS – PERCENTAGE OBLIGATION COMPUTATION

PART I. IDENTIFICATION

A. Special Treatment Program Application

Name (first, middle, last)

Address (number, street)

(city, state, ZIP code)

Date of Eligibility ___/___ (Month) (Year)

E. Redetermination Date ___/___ (Month) (Year)

F. Percentage Obligation %

G. Program
- ❒ Dialysis
- ❒ TPN
- ❒ Supplement

B. MN/MI Medi-Cal Case Name:

C. MN/MI Medi-Cal ID Number					Medi-Cal Special Treatment Program ID Number					Birth Date Month/ Day/Year	Sex	Other Gov. Code	(1) SSN
Co.	Aid	7-Digit Serial Number	FBU	Pers.	Co.	Aid	7-Digit Serial Number	FBU	Pers.				(2) HIC or RR Number

PART II. ELIGIBILITY REQUIREMENTS - SUMMARY

SPECIAL TREATMENT – ONLY, PROGRAM

Percentage Obligation Rate – 2% per $5,000 Annual Net Worth

Dialysis – Only – Aid Code 71

1. Needs dialysis and related services
2. Ineligible for Medi-Cal under any other program due to excess resources
3. Meets Medi-Cal requirements of citizenship/ immigration, residence, institutional status, linkage, and cooperation
4. $250,000 maximum annual net worth
5. Ineligible for Medicare if under age 65

Parenteral Hyperalimentation – Only – Aid Code 73

The applicant must meet ***all*** of the following:
1. Needs parenteral hyperalimentation and related services
2. Ineligible for Medi-Cal under any other program due to excess resources
3. $250,000 maximum annual net worth
4. Be otherwise eligible for Medi-Cal except that linkage requirements are not necessary
5. Meets Medi-Cal requirements of citizenship/ immigration, residence, institutional status, and cooperation

SPECIAL TREATMENT – SUPPLEMENT, PROGRAMS

Percentage Obligation Rate 1% per $5,000 Annual Net Worth

Dialysis Supplement – Aid Code 71

TPN Supplement Aid Code 73

The applicant must meet ***all*** of the following:
1. Needs dialysis or TPN and related services
2. Approved as Medi-Cal with a share of cost
3. Employed or self-employed
4. Earns an individual gross income in excess of the (regular) one-person maintenance need

PART III. ANNUAL NET WORTH COMPUTATIONS

A. Real Property

1. Property used as a home:
   - (a) Full market value $ _____
   - (b) Exempted value $ - 40,000
   - (c) Pro rata encumbrances $ _____
   - (d) Excess market value (a-b+c) $ _____
2. Property not used as a home:
   - (a) Full market value $ _____
   - (b) Encumbrances $ _____
   - (c) Net market value $ _____

Total Real Property (1(d)+2(c)) $ _____

B. Personal Property

3. Liquid Assets – Itemize:
   - _____ $ _____
   - _____ $ _____
   - _____ $ _____
   - Total $ _____
4. Other – Itemize:
   - _____ $ _____
   - _____ $ _____
   - _____ $ _____

Total Personal Property (3+4) $ _____

C. Income

5. Gross earned income for 12 months $ _____
6. Gross unearned income for 12 months $ _____
7. Total gross income (add lines 5 and 6) $ _____
8. Allowable adjustment deductions (per federal tax law) $ _____
9. Total adjusted gross income (line 7 – line 8) $ _____

D. Percentage Obligation Determination

10. Annual net worth (total of A+B+C rounded down to nearest multiple of $5,000) $ _____
11. Percentage obligation factor (line 10 divided by $5,000) $ _____
12. Percentage obligation rate _____ %
13. Percentage obligation – (line 11 multiplied by line 12) Enter in Block F, Part I above _____ %

PART IV. COMMENTS AND SIGNATURE

Medicare effective:	Ineligible Medicare	Discontinued from Aid Code	Effective:
/ /			/ /

Aid Code discontinued because:

Eligibility Worker's signature	Date

MC 176 D (4/99)

INSTRUCTIONS
MEDI-CAL SPECIAL TREATMENT PROGRAMS
PERCENTAGE OBLIGATION COMPUTATION
FROM MC 176D

Form MC 176D, Medi-Cal Special Treatment Programs -- Percentage Obligation Computation, is to be used to determine eligibility and compute the percentage obligation for all applicants for any of the Medi-Cal Special Treatment Programs. This form is completed at the time of a new application, restoration, reapplication, change in net worth affecting percentage obligation, and redetermination. The applicant must also complete an MC 210, Statement of Facts for Medi-Cal, at the time of initial application and at annual redetermination.

The original of the completed form MC 176D is to be sent to:

Department of Health Services
Data Systems Branch
Att: Key Data Entry Unit
P.O. Box 160400
Sacramento, CA 95816-0400

I. How to Complete Form

Part I -- Identification

Block A (Name and Address): Complete for all clients.

Block B (MN/MI Case Name): Complete for Supplement clients.

Block C (Medi-Cal ID Numbers, Birth Date, etc.):

- Enter MN/MI Medi-Cal beneficiary ID numbers for "Supplement" clients. (This additional information is used by the State to claim federal funds for Special Treatment Programs -- Supplement eligibles who have met their MN/MI share of cost.)

- Enter Medi-Cal Special Treatment Program beneficiary ID number for all clients.

- For all clients, enter birth date, sex other coverage code, and HIC number or RR number if Medicare coverage is established. If applicant is not currently eligible for Medicare, a new MC 176D must be sent to the Department's Key Data Entry Unit at the address listed above when notification of Medicare coverage is received.

  NOTE: Medicare eligibility is not a factor in Special Treatment Programs -- Supplement eligibility.

Block D (Date of Eligibility): First month to which this percentage obligation applies. This is the month of initial eligibility or effective month of most recent reevaluation or redetermination.

Block E (Redetermination Date): Date of next annual redetermination. Reevaluation of eligibility will occur before then, when clients advise of changes in circumstances, Medicare eligibility, or submit status reports.

NOTE: Medicare eligibility will disqualify any individual who is under 65 from Dialysis Special Treatment Programs -- Only coverage.

Block F (Percentage Obligation): Enter client percentage obligation from Part III.D, line 13. This percentage will be printed on the Medi-Cal card and on each label.

Block G (Program): Indicate program category for which applicant requests coverage in Part I (G); i.e., TPN Only, Dialysis Supplement, etc. Be sure the Medi-Cal aid code corresponds to this category. Special Treatment Program cards limit the user to certain specified services.

Part II -- Special Treatment Programs Eligibility Requirements -- Summary

See MPG Article 17, Section 1 for detailed explanation of eligibility requirements.

Part III -- Annual Net Worth Computations

A. Real Property

Real property means property used as a home as well as that other real property identified in MPG Article 9, Sections 4 and 5.

1. Property Used as a Home

a. Full market value is the full value amount shown on the most recent tax assessment.

b. Exempted value is $40,000. This amount is subtracted from the full market value.

c. Pro rata encumbrances is that portion of the encumbrance which applies to the part of the home's value above the $40,000 exemption. The general formula is:

$$\text{Pro rata encumbrance} = \frac{\text{nonexempt market value}}{\text{market value}} \times \text{total encumbrance}$$

EXAMPLE:

Full market value: $120,000

Encumbrance (mortgage, etc.): $90,000

Nonexempt value: $120,000 - $40,000 = $80,000

Pro rata encumbrance: $\frac{\$\ 80,000}{\$120,000}$ = 2/3 x $90,000 = $60,000

The pro rate encumbrance is $60,000.

The calculation in Part A would be shown as follows:

A. Real Property

1. Property used as a home:

(a)	Full market value	$120,000
(b)	Exempted value	40,000
(c)	Pro rata encumbrances	$-60,000
(d)	Excess market value	$ 20,000

2. Other Real Property

Determine total full market value of all other real property, less total encumbrances, to find net market value. (See below.)

2. Property not used as a home:

(a)	Full market value	$_____
(b)	Encumbrances	-_____
(c)	Net market value	$_____

B. Personal Property

All property, except that excluded in item 6.C. of this Section will be counted in determining net worth. However, any existing encumbrance is subtracted from the value of personal property.

C. Income

Total annual adjusted gross income is:

1. The adjusted gross income shown on the most recent federal income tax return; or

2. The projected adjusted gross income for the current year, allowing pertinent federal adjustments, providing current income is significantly lesser or greater than income in the preceding year.

D. Percentage Obligation Determination

1. Annual net worth is the total of countable real and personal property plus adjusted gross income. Round the total down to the nearest multiple of $5,000 (i.e., $5,995 is rounded down to $5,000).

2. Percentage obligation is found by dividing the rounded annual net worth (line 10) by $5,000. Beneficiaries with less than $5,000 of net worth will have a "zero percentage obligation."

3. Percentage obligation rate is the rate identified under the program headings. The Special Treatment Programs -- Only rate is two percent; the Supplement rate is one percent.

4. Multiply line 11 by the correct rate. Enter this answer in Part I, block (F).

EXAMPLES: Special Treatment Programs -- All

Family annual net worth is $4,950. This amount is less than $5,000. The percentage obligation will be zero.

Special Treatment Programs -- Only

Family annual net worth is $78,000. Round down to the nearest multiple of $5,000. There are 15 units of $5,000 in $75,000. The percentage obligation will be 15 x 2 percent or 30 percent.

Special Treatment Programs -- Supplement

Family annual net worth is $18,500. Round down to the nearest multiple of $5,000. There are three $5,000 units in $15,000. The percentage obligation rate will be 3 x 1 percent or 3 percent.

II. Miscellaneous Instructions

A. New Cases

Send the original MC 176 D to the Department's Key Data Entry Unit. Retain copies of all pertinent documents in the case file.

B. Continuing Cases, Redetermination Changes, Discontinuances, etc.

1. Use the comments space at the bottom of the MC 176D to indicate what action was taken:

   - Medicare eligibility established effective (date).
   - Ineligible for Medicare, denial notice attached.
   - Discontinued from (program) effective (date) due to (reason).
   - (The Department's Key Data Entry Unit will automatically issue Medi-Cal Special Treatment Program cards until the redetermination date, unless the county notifies them to stop.)

     NOTE: If Supplement beneficiaries become ineligible as an MN or MI, they also lose eligibility for that particular Medi-Cal Special Treatment Programs -- Supplement. Eligibility must then be evaluated under Special Treatment Programs -- Only.

2. Send the original of the revised MC 176D to:

   Department of Health Services
   Data Systems Branch
   Att: Key Data Entry Unit
   P.O. Box 160400
   Sacramento, CA 95816-0400